# Affidavit of Deceased Miner's Condition

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## U.S. Department of Labor

Employment Standards Administration
Division of Coal Mine Workers' Compensation

This report is authorized by law (30 USC 901 et. seq.) While you are not required to respond, your cooperation is necessary to ensure that full and proper consideration is given to this claim.

OMB No. 1215-0056
Expires: 04-30-05

Miner's Name
First Name | M.I. | Last Name

DOL Claim Number

Your Name
First Name | M.I. | Last Name

Relationship to Miner

1. Did you live with the miner?
☐ Yes ☐ No If "Yes," how long? _____ years

2. Were you living with the miner at the time of the miner's death?
☐ Yes ☐ No

3. How long did you know the miner?
_____ Years

4. How often did you see the miner? _____ time per _____ week/mo./yr
Under what circumstances? (Social occasions, working together)

5. a. Do you believe that the miner suffered from any disease of the lung? ☐ Yes ☐ No

If "Yes," what disease(s) do you think the miner suffered?

b. What led you to believe the miner suffered from this disease? (Describe the condition and symptoms)

6. How long did the miner have the symptoms described above?

7. Did the miner's condition limit the ability to walk or perform other activities? ☐ Yes ☐ No

Based on your personal observation, describe the activities the miner was unable to perform.

8. Based on your personal knowledge, how long did the miner have the limitations described above?

**Public Burden Statement**

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding the burden estimate or any other aspect to this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, Room C3526, 200 Constitution Avenue, N.W., Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

To **be completed only If you worked with the miner** In or **around the coal mines.**

9. Was the miner unable to perform his/her assigned job duties? ☐ Yes ☐ No

If 'Yes," state which duties:

10. How long was the miner unable to perform the job duties listed above?

11. To your knowledge, was the miner given different or lighter duties because the miner was unable to perform the usual job duties?

☐ Yes ☐ No If so, describe the changed circumstances of work.

Privacy **Act Statement**

The following information is provided in accordance with the Privacy Act of 1974. (1) Submission of this information is required under the Black Lung Benefits Act of 1977. (2) The information will be used to determine eligibility for and ft amount of benefits payable under the Act. (3) The information may be used by other agencies or persons in handling matters relating, directly or indirectly, to the subject matter of the claim, so long as such agencies or persons have received the consent of the individual claimant or beneficiary, or have complied with the provisions of 20 CFR Part 725. (4) Furnishing all requested information will facilitate the claims adjudication process; and the effects of not providing all or any part of the requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits.

I hereby certify that the information given by me on and in connection with this form is true and correct to the best of my knowledge and belief. I am also fully aware that any person who willfully gives any false or misleading Statement or representation for the purpose of obtaining any benefit or payment under this title shall be guilty of a misdemeanor and on conviction thereof shall be punished by a fine of not more than $1,000 or by imprisonment for not more than one year or both.

| Signature (First name, middle initial, last name) | Date (Mo., day, yr.) |
|---|---|
| | Telephone Number |

Mailing Address (Number, Street, Apt. No. P.O. Box or Rural Route)

| City and State | ZIP Code | County in which you now live (If any) |
|---|---|---|
| city: state: | | |

Witnesses are required ONLY if this application has been signed by mark (X) above. If signed by mark (X) two witnesses to the signing who know the applicant must sign below giving their full address.

| 1. Signature of witness | 2. Signature of witness |
|---|---|
| Address (No., street, city, state, ZIP Code)<br>line 1: city:<br>line 2: state: zip: | **Address (No., street, city, mate, ZIP Code)**<br>line 1: city:<br>line 2: state: zip: |